

**VIRGINIA STATE-30 J-1 VISA WAIVER PROGRAM
J-1 PHYSICIAN ASSURANCES**

I, _____,
Print Full Name

hereby declare and certify, under penalty of the provisions of 18 U.S.C. 1101, that I do not now have pending nor am I submitting during the pendency of this request, another request to any United States Government department or agency or any state department of public health, or equivalent, other than the Virginia Department of Health, to act on my behalf in any matter relating to a waiver of my two-year home-country physical presence requirement.

I further declare and certify that I have no contractual obligation to return to my home country. (If such a contractual obligation exists, the J-1 Physician must obtain a letter of "no objection" from the home country or the embassy in Washington, D.C.)

Initial

I agree to accept assignment under Section 1842 (b)(3)(ii) of the Social Security Act as full payment for all services for which payment may be made under Part B of Title XVII of such Act (Medicare).

Initial

I agree to obtain a medical provider number from the Virginia Department of Medical Assistance Services and sign a contract to provide services to persons entitled to medical assistance under Title XIX of the Social Security Act (Medicaid).

Initial

I agree to provide to the Virginia Department of Health a completed Verification of Employment Form (attached) within 30 days after my employment begins, and every six months thereafter, until my three-year commitment is completed. I understand that failure to submit this report accurately and completely will result in a report of non-compliance to the U.S. Immigration and Naturalization Service.

Initial

Signature

Date